

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175340		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/26/2013	
NAME OF PROVIDER OR SUPPLIER ALDERSGATE VILLAGE				STREET ADDRESS, CITY, STATE, ZIP CODE 3220 SW ALBRIGHT DR TOPEKA, KS 66614			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS			F 000			
F 323 SS=D	<p>The following citations represent the findings of complaint investigation #KS00063467, #KS00066230.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: The facility reported a census of 169 residents and the sample was 7. Based on observation, record review, and interview the facility failed to implement effective interventions to prevent falls for one sampled resident (#1) who fell and sustained a nose fracture.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - Resident #1's quarterly MDS dated 9/12/12 documented two or more non-injury falls, and two or more minor injury falls since admission or the prior assessment. <p>The quarterly MDS dated 12/5/12 documented one minor injury fall since prior assessment.</p> <p>The quarterly MDS dated 2/27/13 documented two or more non-injury falls since prior assessment.</p>			F 323			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175340	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/26/2013
NAME OF PROVIDER OR SUPPLIER ALDERSGATE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 3220 SW ALBRIGHT DR TOPEKA, KS 66614		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 1</p> <p>The annual Minimum Data Set (MDS) 3.0 dated 5/22/13 recorded the resident with a Brief Interview for Mental Status (BIMS) score of 13 which indicated the resident was cognitively intact. The MDS recorded the resident required limited assistance with all Activities of Daily Living (ADL's), and no falls since previous assessment.</p> <p>The Care Area Assessment (CAA) dated 5/22/13 for falls recorded the resident was at risk for falls due to his/her short term memory problems and impulsivity. The resident had impaired balance and an unsteady gait even with the use of his/her walker and staff assistance. The resident fell on 5/25/13 which resulted in a laceration to his/her nose, a nose fracture, and multiple bruises. Interventions in place prior to the fall included wireless bed and chair alarm and staff to ensure the resident had shoes on at all times when out of bed.</p> <p>Fall risk assessments dated 2/27/13, 5/21/13, and 5/25/13 identified the resident as a high risk for falls.</p> <p>The care plan dated 6/12/13 documented an update on 8/19/12 an intervention for a sign placed in the resident's walker to make sure the resident had on shoes before getting out of bed.</p> <p>A nurse's note on 5/25/13 revealed at 4:45 A.M. the resident fell off the toilet (after staff had placed the resident on the toilet) while unattended and landed on his/her face. The resident did not have shoes on at the time of the fall. The facility transferred the resident to the Emergency Room in which a computerized tomography (CT) scan</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175340	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/26/2013
NAME OF PROVIDER OR SUPPLIER ALDERSGATE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 3220 SW ALBRIGHT DR TOPEKA, KS 66614		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 2</p> <p>revealed a left nasal bone fracture and a forehead soft tissue contusion.</p> <p>The care plan revealed an intervention with the start date of 5/25/13 for staff to monitor the resident while on the toilet by standing within arms reach of the resident.</p> <p>An observation on 6/24/13 at 8:33 A.M. revealed the resident ate breakfast and was conversing with the other tablemates.</p> <p>An observation on 6/24/13 at 12:58 P.M. revealed direct care staff D walked with the resident from the dining room chair down the hall. Staff held onto the resident's gait belt while the resident pushed the walker. Direct care staff D offered toileting to the resident and he/she accepted. The resident sat on the toilet, direct care staff D walked out of the bathroom and stood behind the door curtain, which was approximately 5 feet away and waited for the resident to finish. Staff talked to the resident the whole time and peeked in on him/her but staff did not stand within arm's reach of the resident.</p> <p>Interview with direct care staff D on 6/24/13 at 12:52 P.M. stated he/she knew how to take care of the resident because of the 24 hour report sheets that were new every day. For this resident the 24 hour report listed for staff to stay within arms reach of the resident when the resident was on the toilet. Staff D acknowledged he/she did not do that.</p> <p>Interview with administrative nursing staff A on 6/24/13 at 1:05 P.M. stated he/she educated the staff on how to take care of the residents by the</p>	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175340	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/26/2013
NAME OF PROVIDER OR SUPPLIER ALDERSGATE VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 3220 SW ALBRIGHT DR TOPEKA, KS 66614		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 3</p> <p>24 hour report and in shift change report. Staff A would expect the staff to be with the resident as the care plan documented, even though the resident would not have privacy.</p> <p>Interview with direct care staff C on 6/25/13 at 9:39 A.M. stated he/she stayed with the resident at all times even when the resident was on the toilet. The resident tended to lean forward when he/she sat on the toilet and I reminded him/her to sit back. The resident did not mind when staff stayed in the bathroom with him/her.</p> <p>Interview with licensed care staff B on 6/25/13 at 9:49 A.M. stated someone had to be with the resident at all times when he/she walked. When the resident sat on the toilet, the report sheet instructed the staff to stay with the resident because a chair alarm could not be on the toilet. The resident did not mind the staff staying with him/her. Staff B's expectation was for the staff to follow what was written on the sheet.</p> <p>The facility failed to implement planned fall interventions as planned for this resident who had a high risk of falling and a recent fall with injury.</p>	F 323			